TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Universal DME LLC

Respondent Name
Standard Fire Insurance

MFDR Tracking Number
M4-16-1842-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
March 3, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: February 26, 2016, "We should be paid for the services rendered because we have submitted the appropriate paperwork needed, showing that Gallagher Bassett is indeed the correct payer for this claim."

April 21, 2016: "We are still owed a balance of $476.31 for E0217."

Amount in Dispute: $1,110.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our fill audit company has determined additional monies are owed in the amount of $128.52, $76.69, & $372.06. Interest in the amount of $.55, $.33, & $1.60 has been issued."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 18, 2015	L3670, E0217, E0673	$1,110.02	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – Service to be reviewed for payment by DME informal or voluntary network, Coventry DMEplus as defined in Texas Labor Code 408.0284.

- 2 – Original payment decision is being maintained
- W3 – Request for reconsideration
- P12 – Workers' compensation jurisdictional fee schedule adjustment
- Z710 – The charge for this procedure exceeds the fee schedule allowance

Issues

1. What is the applicable rule pertaining to reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier states in their position statement, "Our bill audit company has determined additional monies are owed…" 28 Texas Administrative Code 134.203 (b) states in pertinent part,

   For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

   (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   28 Texas Labor Code §134.203 (d) and (f) states in pertinent parts,

   The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

   (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

   Review of the DMEPOS fee schedule finds the following;

   a. The Medicare, 2015 4th Quarter, Texas Fee Schedule amount found at www.dmepdac.com/dmecsapp/do/feesearch, for submitted codes is as follows:

      - L3670, $102.82 x 125% = $128.52
      - E0217 – RR, $61.35 x 125% = $76.69(Delivery ticket supports (1) unit provided not seven)
      - E0673 – NU, $297.65 x 125% = $372.06

      Total $577.27

2. The maximum allowable for the services in dispute is $577.27. The carrier submitted evidence and the respondent indicated a payment was received for the services in dispute. As the maximum allowable reimbursement was paid, no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Peggy Miller Medical Fee Dispute Resolution Officer	April , 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.